

17 CHARITABLE NONPROFITS AND THE BUSINESS OF HEALTH CARE

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NOT ONLY DO HEALTH CARE ORGANIZATIONS play an outsized role in government spending and the U.S. economy generally, they also play an outsized role in the nonprofit sector. Health care nonprofits make up about 13 percent of all public charities, yet account for the majority of the nonprofit sector's revenues and expenses, and almost half of its assets (McKeever 2015, tables 1 and 2). Because of this extensive economic presence, politicians, scholars, journalists, and others have criticized these giants of the nonprofit world as insufficiently charitable. They find nonprofit health care organizations so dissimilar from their image of conventional charities that they often question whether health care organizations should be considered charities at all.

There are many possible explanations for why the types of charitable health care entities discussed in this chapter—hospitals, insurers, nursing homes, and similar businesses that provide front-line medical care and/or insurance—seem to fit uneasily within the sector. Perhaps some unease has to do with their financing model; nonprofit health care organizations are largely self-sustaining, raising revenues from payments for services rather than from donations. Another potential explanation may be their role in markets; they compete with for-profit and government organizations in the same markets and operate in a manner that is hard for some observers to distinguish from commercial businesses. In fact, patients and insurance beneficiaries often don't know whether the health care organization with which they are interacting is a nonprofit or for-profit. Given the widespread use of for-profit management companies among all types of hospitals, even sophisticated observers may have a hard time identifying the ownership of an entity.

Another source of discomfort could stem from the fact that the larger health care industry is filled with people and organizations that are virtually all for-profit. For example,

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pharmaceutical companies, medical product manufacturers, and medical equipment providers are typically for-profit corporations. In this context, nonprofit health care seems to be only a small part of the medical-industrial complex. Through complex corporate structures and management agreements, lines among nonprofit and for-profit organizations may become blurred.

Furthermore, the members of the medical profession—whether organized in the form of sole proprietors, partnerships, or professional corporations—traditionally have operated as or in for-profit entities. Although observers have not thought of these actors as strictly profit-maximizing, the medical profession has played a principal role in determining the activities of nonprofit health care organizations, such as hospitals, thus raising questions about whether those activities are conducted to benefit physicians at a cost to patients or society at large. As more physicians are directly employed by nonprofit hospitals, questions related to the significance of ownership have loomed even larger.

The common thread among these many arguments for questioning the appropriateness of the nonprofit designation for health care entities is some variant of inappropriate commercialism. Rationalizing the role of health care organizations in the sector, however, may be easier if one considers charitable, nonprofit health care organizations on their own terms rather than in comparison to other types of charities. This chapter attempts to do so. Charitable health organizations do not have to be more like disaster funds, churches, or community theater groups to be appropriately organized as charitable nonprofits and enjoy the related benefits under the law. If one evaluates them as health care organizations, the degree of commercialization no longer seems so inappropriate. Rather, modern health care charities fit into a long charitable tradition, one that is quite different from their for-profit counterparts. This chapter suggests that treating health care charities as legitimate charities would be the wise course.

The health care entities addressed in this chapter are primarily those that (1) are organized as corporations (although some are charitable trusts), (2) consist of big provider organizations (i.e., mainly hospitals, nursing homes, and insurers), and (3) attract the attention of regulators and scholars (unlike more conventional health charities such as those that fund disease research or relieve the suffering of sick children and their families). Importantly, the discussion is limited to legally recognized public charities.

The legal definition of *charity* emerged as a part of the law of trusts during the development of the common law in England, and its formal content can be traced to the 1601 Statute of Charitable Uses (also known as the Statute of Elizabeth), which itself shares striking similarities to passages from William Langland's fourteenth-century poem *Vision of Piers Plowman*. These early definitions of charity include some forms of care for the sick. Ideas from these sources have found their way into modern U.S. tax law (Horwitz 2009).

Modern public charities, including health care charities, have two critical attributes. First, they are private, meaning that they are not owned by the public. Support from the government in the form of tax exemptions and other benefits does not make charities public entities. Second, unlike for-profit entities, they cannot be owned by private owners nor can they adopt the purpose of pursuing profits. Instead, they must have purposes benefiting the public, broadly defined, and these benefits must be identified by founders in a charity's organizing documents. Following convention and the bulk of social science

research on health care charities, this chapter uses the terms *charity* and *nonprofit* interchangeably except when the argument requires that a distinction be made.

This chapter focuses on charities rather than nonprofits more generally for several reasons. First, nonprofit health entities are predominantly public charities, organized as nonprofits under state law and eligible for extensive tax benefits under Section 501(c)(3) of the Internal Revenue Code (i.e., they have enough public support to escape classification as a private foundation). In fact, public charities constitute about two thirds of all registered nonprofits (McKeever 2015: table 1). Second, most of the modern complaints about health care nonprofits stem from the concern that they do not deserve the benefits of charitable status under the law, such as preferential tax treatment. Finally, the general public's understanding of *nonprofit* typically refers to the category of organizations that are public charities (and not noncharitable nonprofits such as country clubs). Nonetheless, because they play such an important role in the health care sector, the chapter also discusses nonprofit insurers, even though they are generally not organized as public charities.

Following this introduction, the next section provides an overview of nonprofit health care in the United States in relation to its for-profit and government counterparts. The section outlines the scale and market share of nonprofit providers, including hospitals, nursing homes, and insurance companies. The section summarizes the number of organizations; revenues, assets, and expenses; utilization; and employment. This discussion illustrates that there is a great deal of variation in the ownership mix of different types of health care organizations.

The third section investigates the history of nonprofit health care entities in the United States and questions the frequently repeated assertion that nonprofit health care organizations, particularly hospitals, have lost their way by changing from fully charitable almshouses providing free care for those in need into fee-charging, ruthless big businesses. Although there is some evidence for a fall from this particular vision of charity, the historical record is more complicated than commonly represented. There is also a long history of nonprofit health care organizations as settings in which physicians used poor patients for training and as fee-charging providers. In short, even the earliest nonprofit health care entities were both charities in good standing and inextricably involved in commercial activity. That some degree of commercialization was built into the model from the beginning is a historical fact that we must recognize and should work to understand.

The fourth section reviews scholarly research about nonprofit/for-profit distinctions among health care entities. Because there are several existing literature reviews on the subject, including in previous editions of this volume, it cites only recent research. It also surveys research concerning a wider range of providers than is commonly addressed in reviews, such as dialysis providers and hospices. The section is organized around the two sets of questions that scholars most commonly address: (1) How do nonprofit, for-profit, and (less commonly) government-owned health care organizations differ? (2) Do nonprofit health care organizations merit federal and state tax exemptions? The scholarship that answers the first question frames nonprofit organizations as a form of health care organization—finding mainly favorable results when compared to other ownership forms. The scholarship that addresses the second question thinks of nonprofit health care organizations primarily as nonprofits, and from that perspective finds them wanting.

The fifth section turns to the legal and policy landscape. It observes that nonprofit health care organizations are treated quite differently—sometimes more favorably and other times less favorably—from both other nonprofit organizations and other health organizations. Drawing on previous work (Horwitz 2016), the section highlights a few salient examples and considers the justifications, sometimes explicit and at other times implicit, for the disparate treatment. It finds no consistent justification, and often no justification at all, for the variable treatment of nonprofit health providers, by either health law or nonprofit law. Indeed, their treatment often seems to operate at cross purposes, with the law sometimes favoring and at other times disfavoring the same entities for the same expected behavior.

The chapter concludes that there is a strong case to be made for contemporary nonprofit health care entities as charities in good standing, in light of both their current behavior and their history. The conclusion suggests that the critiques of charitable health care entities are misplaced and that, given both the history of health care entities and their modern context, we have much to gain by treating them as fully legitimate charities.

Ownership Landscape[†]

Health Care Nonprofits as Nonprofits

Depending on which measure one assesses, health care organizations play either a small or a large role in the nonprofit charity landscape. In several respects, they are quite small. As can be seen in Table 17.1, between 2000 and 2013, health care organizations have accounted for a high of 14.4 percent and a low of 12.1 percent of all charities. In fact, hospitals and primary care facilities have ranged from only 1.0 to 2.8 percent of charities. They also account for only a small percentage of total contributions received by charities. For example, in 2009, they received 7.4 percent of all charitable contributions, and in 2014 they accounted for 8.5 percent of all charitable contributions (McKeever 2015: table 5).

In other respects, they are the giants of the sector. In terms of finances, health care nonprofits dwarf other types of nonprofits. As can be seen in Table 17.2, between 2000 and 2013, they accounted for between 55 and 60 percent of total revenues, about 60 percent of expenses, and between 39 and 43 percent of all assets in the nonprofit sector. Hospitals and primary care facilities alone, despite representing such a small number of charities, account for most of the revenues (as can be seen in Figure 17.1), expenses, and assets of all health charities. To give a sense of scale, in terms of finances, educational institutions—including higher education and all others—come in second on these measures. However, as can be seen in Figure 17.2, despite these high levels of revenues and assets, on average, nonprofit hospitals' operating margins are negative in a given year.

Nonprofit health care organizations are also major employers in the health care sector. In 2012, they constituted 46 percent of private employment in the health care and social assistance industries, and those industries capture 68 percent of all nonprofit employment

[†] The author estimated all statistics that are presented without a citation. The underlying data are from the American Hospital Association's Annual Survey of Hospitals for the year reported. Percentages in this section may not total 100 because of rounding.

Table 17.1 Number and percentage of nonprofit health care organizations (selected years, 2013–2000)

<i>Type of charity</i>	<i>2013</i>	<i>2011</i>	<i>2010</i>	<i>2009</i>	<i>2007</i>	<i>2005</i>	<i>2004</i>	<i>2000</i>
<i>Number of charities</i>								
Health	37,732	41,619	44,128	44,130	42,880	41,243	38,633	36,057
Hospitals and primary care facilities	7,062	7,308	7,657	7,526	7,360	5,045	3,139	6,929
Other health	30,670	34,111	36,471	36,604	35,520	36,198	35,494	29,128
All public charities	293,103	335,037	366,086	362,926	342,995	310,683	299,033	249,859
<i>Percentage of charities</i>								
Health	12.90%	12.40%	12.10%	12.20%	12.50%	13.30%	12.90%	14.40%
Hospitals and primary care facilities	2.40%	2.20%	2.10%	2.10%	2.10%	1.60%	1.00%	2.80%
Other health charities	10.50%	10.20%	10.00%	10.10%	10.40%	11.70%	11.90%	11.70%
Other public charities	87.10%	87.60%	87.90%	87.80%	87.50%	86.70%	87.10%	85.60%

Notes: These data are from Urban Institute reports that contain summary information from the National Center for Charitable Statistics, Core files. They include information only from public charities that reported to the IRS on Form 990 and were required to do so based on gross receipts. Organizations that had their tax-exempt status revoked for failing to file were not included. Virtually all of the charities discussed in this chapter should be included in these data.

Sources: Data for 2013 from McKeever 2015, table 2, p. 51. Data for 2011 data Pettijohn 2013, table 2. Data for 2010 and 2000 from Blackwood, Roeger, and Pettijohn, table 3. Data for 2009 from Roeger, Blackwood, and Pettijohn 2011, table 2. Data for 2007 from Wing, Roeger, and Pollak 2009, table 2. Data for 2005 from Blackwood, Wing and Pollak 2008, table 2. Data for 2004 from Urban Institute 2007, table 3, p. 49.

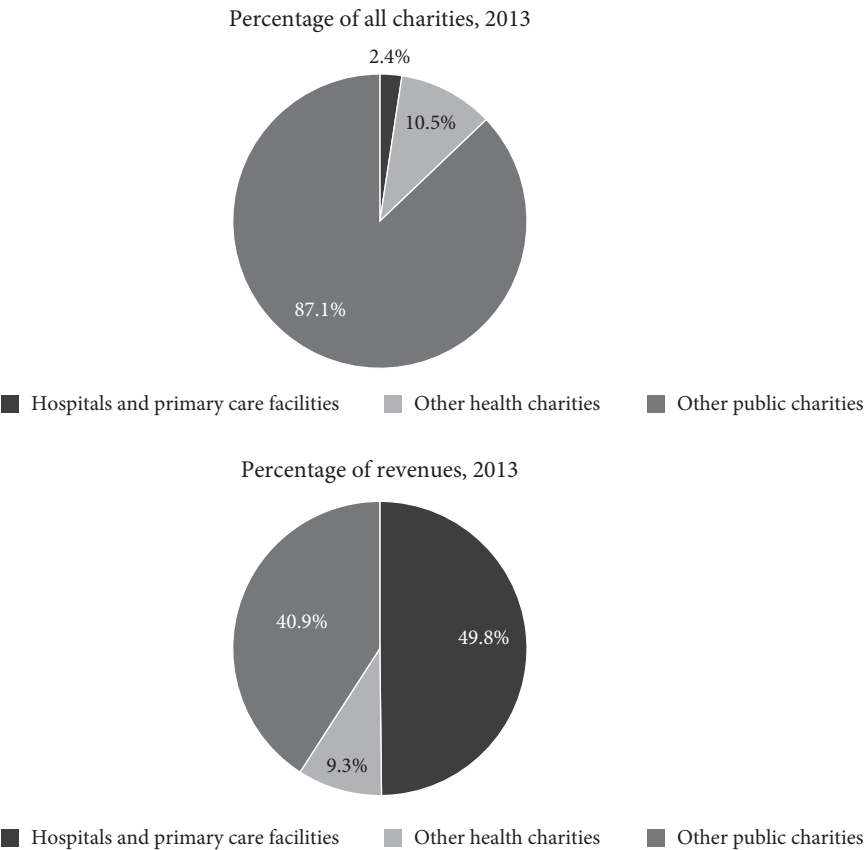


Figure 17.1 Health care charities: percentage of all charities and percentage of revenues, 2013

Notes: These data are from Urban Institute reports that contain summary information from the National Center for charitable statistics, Core files. They include information only from public charities that reported to IRS on a form 990 and were required to do so based on gross receipts. Organizations that had their tax-exempt status revoked for failing to file were not included. Virtually all of the charities discussed in this chapter should be included in these data.

Source: Data from McKeever 2015, table 2, p. 51.

in 2012 (Friesenhahn 2016). Hospitals alone accounted for 4 million jobs—35 percent of nonprofit employment—with nursing and residential care adding another 1.2 million jobs (Friesenhahn 2016).

Ownership and Division of Labor in the Health Care Industry

There is less of a clear division of labor among ownership types in the production of health care than in other areas of endeavor in which nonprofits are prominent. For example, producers of activities conventionally thought to be the high arts—ballet and modern dance companies, orchestras, operas, chamber music organizations, and art museums—are almost all nonprofits. On the other hand, dinner theaters, jazz ensembles, circuses, and

dance schools are almost all for-profit (DiMaggio 2006). Although nonprofit schools exist at all levels—from preschool through postgraduate school—there is some specialization. More than half of child care centers are for-profit (Sosinsky, Lord, and Zigler 2007). From fall 1999 through fall 2015, between 9.6 percent and 11.7 percent of elementary and secondary students were enrolled in private schools (National Center for Education Statistics 2018: fig. 1). Among four-year-degree-granting institutions with first-year undergraduates, there were more private nonprofits (1,295) than public schools (698) or for-profits (402) during 2016–2017 (Institute of Education Sciences 2018:178). However, public (885) and for-profit (518) schools dominated two-year institutions, with only 97 nonprofits in 2016–2017 (Institute of Education Sciences 2018).

In contrast, nonprofit, for-profit, and government health care organizations tend to compete directly against each other in the same markets, and to a great extent they offer the same general types of services such as hospital services, hospice, or nursing home residences.

Hospitals. Among general medical and surgical hospitals, excluding federal hospitals (e.g., military, Department of Justice [prisons], Bureau of Indian Affairs, and veterans’

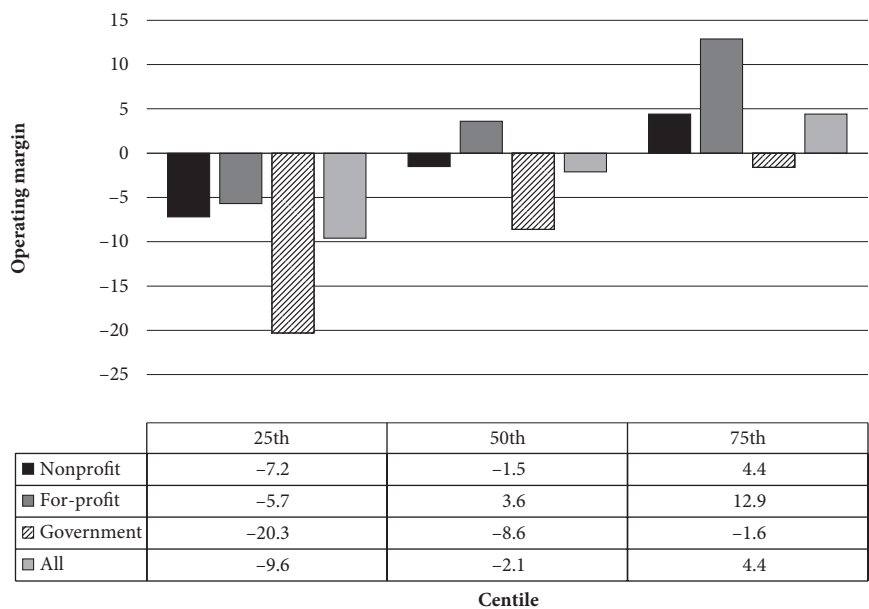


Figure 17.2 Hospital operating margins, 2012

Notes: Data include all general medical and surgical hospitals excluding military and federal Department of Justice hospitals. Operating margins defined as (Total Patient Revenues–Contractual Allowances–Total Operating Expenses)/(Total Patient Revenues–Contractual Allowances).

Source: Author’s analysis of data from the American Hospital Association Annual Survey 2012 and the Centers for Medicare & Medicaid Services Health Care Cost Reports 2012.

Table 17.2 Revenues, expenses, and assets of health care charities and all public charities (selected years, 2013–2000)

	2013	2011	2010	2009	2007	2005	2004	2000
<i>Revenue (in billions \$)</i>								
Health	1,025.30	942.4	907.7	842.7	788.7	672.131	616.449	459.4
Hospital and primary care	864	798.5	773.4	716	663.5	492.498	446.433	383.2
Other health	161.3	143.8	134.3	126.7	125.2	179.633	170.016	76.2
Total public charities	1734.1	1593.6	1514.2	1399.3	1399.7	1144.022	1050.134	836.9
<i>Expenses (in billions \$)</i>								
Health	975.8	895.3	missing	827.5	739.4	637.323	588.299	missing
Hospital and primary care	823.9	758.4		698.7	626.4	468	426.672	
Other health	151.9	136.9		128.8	113	169.323	161.627	
Total public charities	1623.8	1498.2		1399.9	1251.9	1053.487	981.271	
<i>Assets (in billions \$)</i>								
Health	1392.8	1202.6	1141.8	1046	1003.2	826.159	748.34	606.9
Hospital and primary care	1133.5	973.3	926.9	844	792.8	608.836	539.604	468.2
Other health	259.3	229.3	214.9	202	210.4	217.323	208.736	138.7
Total public charities	3225	2856	2708.9	2533.6	2576.8	1975.792	1819.32	1500.2

Notes: These data are from Urban Institute reports that contain summary information from the National Center for Charitable Statistics, Core files. They include information only from public charities that reported to IRS on Form 990 and were required to do so based on gross receipts. Organizations that had their tax-exempt status revoked for failing to file were not included. Virtually all of the charities discussed in this chapter should be included in these data. \$ billion are reported in each year's dollar value, unadjusted.

Sources: Data for 2013 from McKeever 2015, table 2. Data for 2011 from Pettijohn 2013, table 2. Data for 2010 and 2000 from Blackwood, Roeger, and Pettijohn, table 3. Data for 2009 from Roeger, Blackwood, and Pettijohn 2011, table 2. Data for 2007 from Wing, Roeger, and Pollak 2009, table 2. Data for 2005 from Blackwood, Wing, and Pollak 2008, table 2. Data for 2004 from <https://www.hplct.org/assets/uploads/files/Nonprofit%20Almanac.pdf> Pp. 50

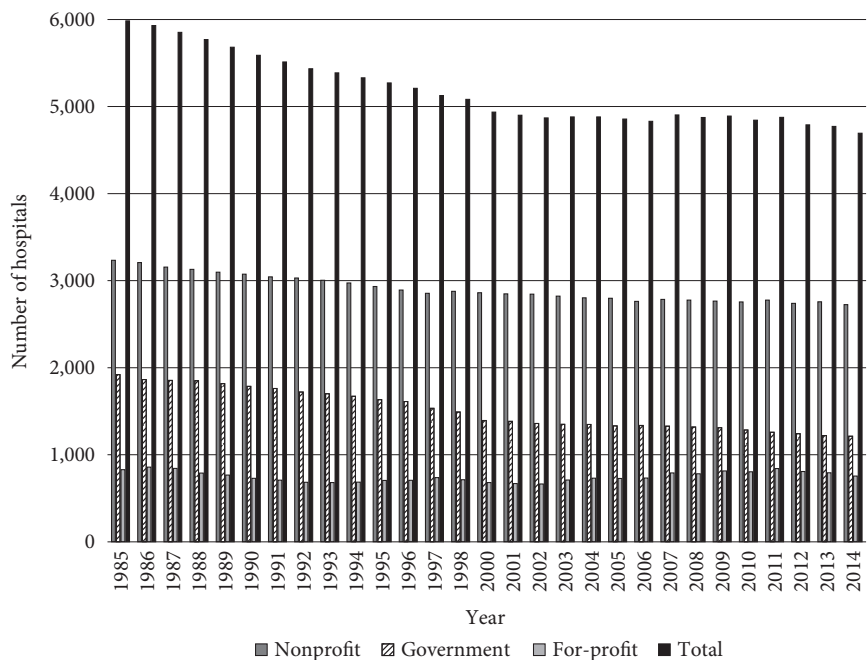


Figure 17.3 Number of general medical and surgical hospitals by ownership type, 1985–2014
Source: Author’s estimates based on all hospitals reporting to the American Hospital Association’s Annual Survey 2014.

hospitals), in 2014 about 58 percent were nonprofit, 26 percent were government, and 16 percent were for-profit owned. A great deal of ink has been spilled discussing the rise of for-profit health care, particularly in the hospital sector. And, indeed, there has been some for-profit growth even though the total number of hospitals has been falling. However, because of closures and conversions to and from nonprofit and government ownership, as can be seen in Figure 17.3, the distribution has been remarkably stable over time. Among all general medical and surgical hospitals, urban and rural, there was about a 2.24 percentage point increase in the number of for-profit hospitals from 1985 to 2014, although the number of nonprofit hospitals increased by about double that amount over the same period.

More substantial growth in for-profit hospital care can be seen if one measures total admissions by ownership form rather than by the number of hospitals. For example, in 1985 only 9 percent of admissions were to for-profit hospitals, with 67 percent at nonprofits and 23 percent at government-owned hospitals; by 2014, these admission levels were 15 percent, 70 percent, and 15 percent respectively.¹

As with education, the ownership mix of hospitals differs by specialty. For example, as can be seen in Figure 17.4, in 2014, most children’s hospitals were nonprofit (over 90 percent). In contrast, over 82 percent of both heart and orthopedic specialty hospitals, which tend to be very profitable, were for-profit. Even within types of specialties, hospitals of different ownership further specialize. Nonprofit hospitals make up the bulk of

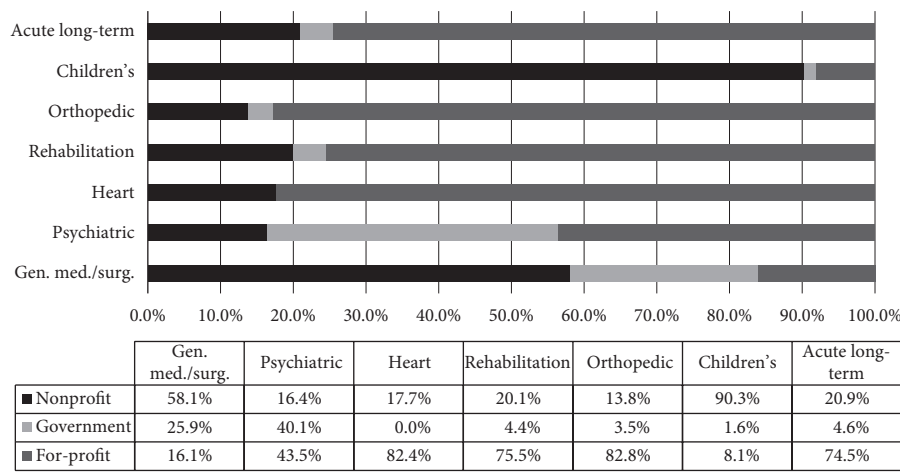


Figure 17.4 Percentage of hospitals by ownership type, 2014
Source: Author’s calculations from all hospitals reporting to the American Hospital Association’s Annual Survey 2014.

all teaching hospitals, which constitute about 6 percent of general medical and surgical hospitals; in 2014, 62 percent were nonprofit, 35 percent were government-owned, and 3 percent were for-profit.² Among general medical and surgical hospitals, nonprofit hospitals are also by far the most likely to run an American Medical Association–approved residency program; in 2014, 67 percent were nonprofit, 21 percent were government-owned, and 12 percent were for-profit.³

The mix of hospital types also varies by whether an area is densely or sparsely populated. In the most populated areas (metropolitan divisions), with some variation over time, nonprofits account for just under two thirds of hospitals (62 percent in 2014), government-owned hospitals account for 18 percent, and for-profit hospitals make up around 20 percent. The more rural⁴ the area, the more likely a hospital is to be government-owned (in 2014, 43 percent of rural hospitals) or nonprofit (48 percent) and the less likely a hospital is to be for-profit (9 percent).⁵

Nursing homes. In 1983, Bruce Vladeck wrote that “Nursing Homes are the most numerous health-care institutions in the United States, though hardly the most visible or best understood” (Vladeck 1983:352). Although scholars have substantially increased the attention they give to nursing homes, they are still understudied in relation to hospitals. As can be seen in Table 17.3 and Figure 17.5, nursing homes are largely for-profit, with nonprofits a far second, and government nursing homes a distant third. Between 2004 and 2014, the number of nursing homes declined slightly. Over the same period, for-profit nursing homes increased their market share (from 61.5 percent in 2004 to 69.8 percent in 2014), while the market shares of nonprofit and government nursing homes declined (nonprofit from 31.1 percent to 24.0 percent; government from 7.5 percent to 6.2 percent).

Table 17.3 Number of nursing homes by ownership type, 2004–2014

	<i>For-profit</i>	<i>Nonprofit</i>	<i>Government</i>	<i>Total</i>
2004	9,900	5,000	1,200	16,100
2005	10,582	4,495	955	16,032
2006	10,578	4,381	964	15,923
2007	10,639	4,278	940	15,857
2008	10,621	4,167	914	15,702
2009	10,644	4,143	915	15,702
2010	10,741	4,009	896	15,646
2011	10,824	3,951	898	15,673
2012	10,814	3,897	919	15,630
2013	10,887	3,815	936	15,638
2014	10,913	3,756	971	15,640

Sources: Data for 2004 are from “Nursing Home Facilities: December 2006.” *Centers for Disease Control and Prevention*, table 1, p. 1. Data for 2005–2014 are from “Nursing Home Data Compendium 2015 Edition.” *Centers for Medicaid & Medicare Services*, 2015, figure 1.3, p. 11.

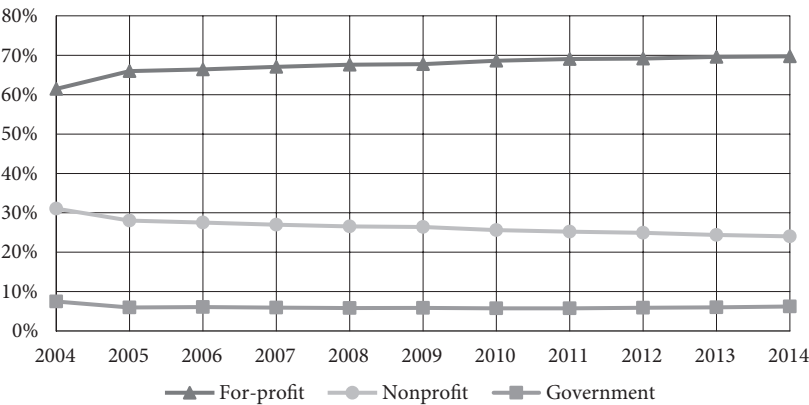


Figure 17.5 Percentage of nursing homes by ownership type, 2004–2014

Sources: Data for 2004 are from Centers for Disease Control 2006, table 1. Data for 2005–2014 are from Centers for Medicare & Medicaid Services, 2015, figure 1.3.

Other health care providers. A mix of owners can also be found among other types of providers. The hospice industry has seen a dramatic change in ownership (Stevenson et al. 2016; Thompson, Carlson, and Bradley 2012). For-profit share grew from 5 percent to about 51 percent of the hospice industry from 1990 to 2011 (Aldridge et al. 2014). Since then, the share of for-profits has climbed to well over 60 percent, with year to year variation. In 2016, 67 percent of Medicare-certified hospice facilities were for-profit, 29 percent were nonprofit, and the remaining 3.9 percent were government (National Hospice and Palliative Care Organization 2017).

Home health care providers are even more likely to be for-profit. In 2014, 80 percent were for-profit, 15 percent were nonprofit, and the remaining 5 percent were government-owned (Centers for Disease Control and Prevention 2017).

Health Insurers. As with other subsectors in the health care sector, nonprofits are only part of the insurance landscape. Americans with health insurance are covered by for-profit, nonprofit, and government-sponsored plans. In 2016, 35 percent of Americans had government insurance through Medicare, Medicaid, or other public systems (Kaiser Family Foundation 2016). Fifty-six percent of Americans were covered by employer or nongroup plans, and these included a mix of nonprofit and for-profit insurers.

As with recipients of services from other organizations in the health care field, many insurance beneficiaries do not know whether they are insured by the government, for-profit companies, or nonprofit companies. Some beneficiaries of government-sponsored insurance receive some or all of their coverage through private insurance contractors. Many people who are covered by employer-sponsored insurance interact with a commercial (nonprofit or for-profit) insurance company for customer service, but their underlying insurance is provided by their employer, not the insurance company that contracts with the employer for administrative services such as processing claims and performing utilization review or gatekeeping functions.

Nonetheless, among the large health plans in the United States (i.e., those with at least 100,000 enrollees) in 2012, 63 percent (97 plans) were nonprofit and 27 percent (41 plans) were for-profit, with the remaining 10 percent (16 plans) being government-owned (Alliance for Advancing Nonprofit Health Care 2012). For-profit companies, however, are larger. Therefore, about half of enrollees were covered by nonprofits and slightly fewer by for-profits in 2012; nonprofits covered 50 percent of fully insured beneficiaries and 45 to 53 percent of total beneficiaries, including those insured by their employers, while for-profits covered 47 percent of fully insured beneficiaries and 53 percent of total beneficiaries, including those insured by their employers (Alliance for Advancing Nonprofit Health Care, 2012).

Among nonprofits, the landscape is also complicated. Nonprofit insurers may be legally organized as charities under state incorporation law. However, the bulk of them are not eligible for the extensive tax benefits associated with I.R.C. 501(c)(3) or I.R.C. 501(c)(4). Rather, since 1986, they have been governed by I.R.C. 501(m) as providing “commercial type insurance,” which roughly includes all insurers that provide indemnity insurance, such as traditional Blue Cross and Blue Shield plans. Moreover, many nonprofit insurance companies are organized as mutual nonprofits, entities owned by policyholders; any excess premiums are reinvested in the insurer or given to the members through dividends or reductions in premiums. Under the Internal Revenue Code, mutual insurers—that is, 501(c)(15)s—are tax-exempt but receive fewer tax benefits than public charities under 501(c)(3).

Finally, health maintenance organizations (HMOs), which are a hybrid of medical provider and insurer, may be organized as nonprofits under state law. Their history of tax exemption has been volatile. Although 501(m) did not apply to them as they did not provide commercial insurance, the tax exemptions of HMOs—some under 501(c)(3), but mostly under 501(c)(4)—have been increasingly challenged by the IRS.

The preceding discussion highlights the central and enduring role of health care entities among charities and of charities among health care entities. At the same time, it documents some of variation among these entities.

Nonprofits and Commercialization in Historical Context

The distorting effects of profit-seeking among nonprofits—museums generating more revenue from gift shops, restaurants, and parking than from admissions, and megachurches with onsite Starbucks franchises and gyms—have long troubled scholars (see, e.g., Colombo 2002, 2007b; Weisbrod 1998). Nonprofit hospitals, however, are frequently identified as the canonical example of charities that have taken an impermissible commercial turn.⁶ In some respects, their reputation has been earned. For example, today many nonprofit hospitals use complex corporate structures, often involving collaborations and formal affiliations with for-profit entities (e.g., Colombo 2002). Indeed, among nonprofits that have some taxable revenues, health care nonprofits are second only to housing nonprofits in their propensity to use taxable subsidiaries. Their for-profit partners account for over 60 percent of all taxable subsidiaries of nonprofits (Yetman and Yetman 2008). Moreover, health care nonprofits' commercial behavior, including profit-seeking, tends to increase with increased competition with for-profits (Horwitz and Nichols 2009; Levitt 1986).

Among the most prominent and disapproving charges made against modern nonprofit health care organizations, particularly hospitals, is that they have lost their way from their charitable roots as almshouses, where care was once freely given to those in need. David Rosner's (1982) classic study of hospitals in New York dates the shift from a paternalistic service orientation to a bureaucratic, medical, and business orientation to the late nineteenth and early twentieth century. Daniel M. Fox (2013:102) observes that "the values and principles of governance embraced by leaders of non-profit organizations, and especially of hospitals, have contributed to the growing commercialization of the health sector during the past half-century." Relying on Rosner's account, Fox (2015) also identifies the beginning of commercialization as the late nineteenth century and traces what he sees as a paradox—a history of health policy incentives that led to both the expansion of nonprofit health enterprise and its commercialization. However, according to Fox, a move away from commercialization began in 2010 when the ACA "encourage[d] tax-exempt organizations to contribute to the public good" (Fox 2015:180).

Others speak more generally about the long-term trend. For example, according to Adam Reich (2014b:10), "early hospitals in the United States were indistinguishable from almshouses, and guaranteed the poor a basic (if limited) right to care." Although he recognizes that almshouses need to be understood in their historical context, he is one of many writers who paint a glorified picture of almshouses and early hospitals in comparison to which modern entities fall short. He explains that hospitals are losing the struggle to maintain local ties because they operate in an "increasingly market-driven institutional environment" (Reich 2014a:1578). Cecilia McGregor (2007) traces her overview of charity back to Egypt in service of an argument that charities should provide free care for uninsured and inadequately insured patients.

More boldly, Kerry O'Halloran (2012:4) claims that "'Profit' and 'charity' are not readily reconciled." Her definition of charity leans heavily on Richard Titmuss's (1970) concept of

gifts and altruism, which argued that charity becomes tainted (literally in his study documenting inferior blood donations) when mixed with commerce. According to O'Halloran's account, although charities have had business interests in the past, the focus on business has increased dramatically (O'Halloran 2012:123). Health care in the United States is offered as a prime example, in large part because the United States does not have universal public health insurance or a government-owned hospital system. Quoting congressional testimony on nursing home shortages from 1965, she endorses the story of the fall of health care charities: "The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy . . . is largely anachronistic" (O'Halloran 2012:265).

Although it is beyond the scope of this chapter to address the comparative claims about national health care systems, observers often fail to acknowledge that (1) a great deal of health care in the United States is covered by public payers and (2) other national systems substantially involve nongovernmental actors (e.g., pharmaceutical insurance in Canada). Nonetheless, there is a strong argument to be made that patients in the U.S. system, which relies on a greater share of private care provision (both for-profit and charitable) than other systems, are likely to benefit from more of those providers being charitable since charities are less likely to prioritize profit-making than are for-profits. This observation does not mean that all providers should be charities. Given the massive cost of modern medicine, even subtracting generous estimates of overhead and profits in the current system, there is simply no possibility that charities could meet the health care needs of the U.S. population. And, as this section explains, they never fully did.

The historical record of nonprofit health care organizations in America (and elsewhere) does not support the story of a linear transformation from early providers of free care for the needy to modern charitable nonprofits degraded by commercialization.⁷ At a minimum, the early history shows that if nonprofit status and commercialization of health care is an American paradox, it began with colonial health care endeavors. Some early hospitals were charitable in the popular sense of the word, but (1) many did not grow out of almshouses but in fact treated inmates from neighboring almshouses for payment; (2) there is considerable evidence of commercialization among charities, beginning with almshouses themselves and the earliest hospitals (which were largely self-supporting); and (3) nonprofit health care organizations have always, at times to a greater and lesser degree, operated in a system of private markets. This section takes each of these observations in turn.

Did Modern Health Care Entities Have Their Roots in Almshouses?

Evidence that hospitals grew out of almshouses is mixed. In some cases, doctors treated inmates in almshouses, and almshouses sometimes had infirmaries to treat inmates who could not be treated in the living quarters of the poorhouse. For example, the infirmary in the Philadelphia Almshouse was known as the Philadelphia Hospital (Packard 1963). Some hospitals that were affiliated with the almshouses subsequently separated from them or took them over entirely, transforming them into hospitals (Dowling 1982). A government almshouse could transform into a government hospital, as in the case of the Baltimore City Hospital, which did not separate from the Baltimore City Department of Public Welfare until 1964 (Kerson 1981).

In other places, hospitals were always separate institutions (Dowling 1982). For example, early colonial almshouses, such as those established in the 1600s in Virginia, New Amsterdam, and Boston, did not become hospitals even though they cared for the sick (Dowling 1982). The example of the country's first true hospital, founded in 1751, is illustrative. According to its founder, Benjamin Franklin, the Pennsylvania Hospital was established as an independent charity for the poor and sick, funded mostly by private subscription but, because donations were insufficient, with additional funding from the Pennsylvania Assembly (Cohen 1954). Unlike the Philadelphia infirmary, it did not limit treatment to a group of residents (Price 1985).

In fact, it is not modern hospitals but nursing homes that most directly emerged from almshouses. Sidney Watson's (2010) detailed account of the history of the nursing home industry traces the development of nursing homes from almshouses, which were originally used only when home care was unavailable. She describes how "the feeble elderly, chronically ill, physically disabled, and those with mental retardation" remained in county and municipal almshouses into the early twentieth century (Watson 2010:941). For example, a report from the 1930s about Missouri almshouses describes rural almshouses as farms, run by farmers who received pay to keep inmates. The report criticized these facilities, stating that they were "ill adapted to care for all the types of cases which they receive, have little or no hospital facilities or special provisions for the care of mental cases and are likely to be managed by unqualified and incompetent personnel" (Pihlblad 1938:204). The growth of public payment systems, with inadequate budgets, led to the creation of rest, nursing, and convalescent homes in which frail, elderly, and disabled poor people could receive housing and some care, albeit often substandard (Watson 2010). Thus, the organizational heirs to the almshouse are, and have always been, predominantly for-profit rather than nonprofit entities.

Almshouses, Hospitals, and Payment by Poor Patients

There is plenty of evidence to verify that charity—in the form of giving help without expectation of monetary reward—has been provided by some almshouses and nonprofit health care organizations since their earliest appearance in the United States. Almshouses were founded to help the poor, vagrant, and sick who could not find housing or sustenance elsewhere. Similarly, the charter of the Massachusetts General Hospital, founded in 1811, required it "to support thirty sick and lunatic persons who were charges of the state," although later the requirement was changed to depend on the income available to the hospital from sales of property donated by the Commonwealth (Commission on Hospital Care 1947:439). The petition to the Pennsylvania legislature to found the Pennsylvania Hospital portrays precisely the vision of charity contemporary critics imagine modern hospitals should fulfill:

The kind Care of our Assemblies have heretofore taken for the Relief of sick and distempered Strangers, by providing a Place for their Reception and Accommodation, leaves us no Room to doubt an equal tender Concern for the Inhabitants. And we hope they will be of Opinion with us, that a small Provincial Hospital, erected and put under proper Regulations, in the Care of Persons to be appointed by this House, or otherwise, as they shall think meet, with Power to receive and apply the charitable Benefactions of good People towards

enlarging and supporting the same, and some other Provisions in a Law for the Purposes above mentioned, will be a good work, acceptable to God and to all the good People they represent.” (Packard 1963:182).

However, the operations of the almshouses and hospitals were always more commercial than this aspirational language would suggest. Some inmates in almshouses were so sick, old, or physically or mentally disabled that they could not work—but everyone else did. At a minimum, inmates helped run the almshouse. For example, poor women were busy “preparing food, making and washing clothing and bedding, birthing and raising children, nursing the sick, tending the handicapped, laying out the dead” (Herndon 2012:351). In 1835, Philadelphia’s Board of Guardians of the Poor—the entity with the authority to collect a poor tax and distribute it to the indigent—prioritized admission to the almshouse for female inmates according to whether they were aged and helpless women in bad health; could sew and knit; or were good sewers, spinners, scrubbers, and washerwomen (Rosenberg 1977). Sewing appears to have been important. Those who refused to work were compelled by force. “Although the Maryland almshouse was supported through taxes, those poor who were able to work could be compelled to do so by the overseer in the almshouse or workhouse; refusal subjected the person to no more than thirty-nine lashes” (Quigley 1997:126).

The almshouses were themselves workhouses or attached to workhouses, or they contracted out inmates as workers. Inmates farmed, whitewashed buildings, and maintained and repaired the grounds and buildings (Bourque 2012). In fact, during the antebellum period, the Philadelphia almshouse established a manufactory to produce textiles, hoping to compete with British imports (Bourque 2012). Some inmates worked for their keep; some were paid cash for their work; some worked in exchange for “goods, liquor, and the approval of supervisors” (Bourque 2012:388). Some also held paid jobs offsite. In worse cases, for example in Maryland, “the Trustees of the Poor were given the right to bind out, or indenture, any poor child or orphan under their care in the poor house” (Kerson 1981:204).

Lest one believe that these activities were conducted exclusively for the purpose of developing job skills for the benefit of the residents, rather than reflecting a commercial orientation among almshouse or hospital boards, consider how those unable to work were treated. In response to the increasingly unmanageable crowds that came to stare at patients through the windows to their cells, in 1767 the board imposed a fee on those who wished to observe patients who were in the hospital because of lunacy—essentially transforming them into a sideshow—and only removed it twenty-four years later because of injury to the patients (Packard 1963).

As the earliest hospitals emerged—either in conjunction with or separately from almshouses, as discussed previously—they were largely self-supporting and, therefore, engaged in commercial endeavors. During the late eighteenth century, the Pennsylvania Hospital imported medicine and sold it at a profit; it also ran working farms that, in addition to supplying the hospital with milk and produce, brought in revenues through external sales (Dorner 2016).

The earliest hospitals also charged for treatment of some poor patients. There are records of the managers of the Philadelphia Hospital negotiating its rates with the Pennsyl-

vania Almshouse to admit sick almshouse inmates to the hospital. The hospital sometimes reduced its fees to settle the debts of the almshouse and, at least in the spring of 1799, admitted six patients without pay; at other times the hospital refused to treat almshouse patients for free because of the expense (Packard 1963). Even poor patients who were admitted for free treatment were required to bring a security deposit from the local overseer of the poor as indemnification, so that the hospital would not be stuck paying for the transport or burial of the patient's dead body. The security was required "in case they die, or to defray the expense of carrying them back to their place of abode, and that they may not become a charge of the city" (Packard 1963:196).

Perhaps more costly to patients than compelled labor, being ogled, or paying for services were the payments they made with their bodies as objects of experimentation and medical study. As Gert H. Brieger noted, "As early as 1769, Samuel Bard of New York remarked that 'the nature of diseases, and the practice of medicine cannot be taught but in a public hospital'" (1972:233). The role of nonpaying patients as teaching material has persisted in charitable health care organizations from their earliest days and into the modern context (e.g., Dowling 1982; Brieger 1972; Vogel 1978:174). In some cases, recognition of the opportunity for training subjects inspired the shift from almshouse to hospital. For example, the Maryland almshouse began transforming itself into a medical institution when "the potential of the Almshouse as a teaching facility for a medical school began to be appreciated" (Kerson 1981:205).

Medical residents paid the almshouses and hospitals to hone their practice, which appears to have involved treating most complaints with "bleeding, purging, and puking" (Price 1985:387). This use of patients as subjects caused John Jones, physician to Benjamin Franklin and George Washington, to remark, "Among the variety of public errors and abuses to be met with in human affairs there is not one, perhaps, which more loudly calls for a speedy effectual reformation than the misapplied benevolence of hospitals for the sick and wounded" (Brieger 1972:238).

Given this long history of inmates and patients' payment for health care in the form of money, labor, and their bodies, it is a stretch to characterize almshouses and early hospitals as providing services as gifts to the needy. These relationships included some forms of conventional charity, but they can nonetheless be accurately characterized as commercial. The history does not suggest that contemporary health care nonprofits that charge fees and limit free services have strayed far from their roots.

Medicine for the Non-Indigent

Until the end of the nineteenth century, people who were sick entered hospitals only if they had no other options. At that time, you would stay at a hospital only "if you could not afford care at home, had no relatives to help provide nursing, or lived in such crowded tenement quarters that there was no room for a sick person" (Brieger 1972:235). Countless descriptions of the fetid and dangerous conditions, such as one story from a newspaper in 1860 of rats devouring a newborn's face, make clear why these environments were avoided by anyone with the means to do so (Brieger 1972; Dowling 1982).

Therefore, most people received care outside the hospital. Moreover, the care that they received was as inescapably commercial as it is today, and perhaps even more so.

First, throughout the history of the United States, sick people and their families have paid physicians out of pocket for their care, only very recently via insurance. For example, in the nineteenth century, people diagnosed themselves and determined when to find a physician and pay for treatment.

As a result, medical practice developed as a form of self-employment, in which the physician received his earnings from fees obtained for services rendered on a voluntary case-by-case basis. Physicians in the nineteenth century competed for the patient's dollar not only with other physicians, but also with lay and part-time practitioners, who frequently charged less than physicians and provided serious competition for them during much of the period. (Rothstein 1972:13).

The transformation of nineteenth-century to twentieth-century medicine has been one of increasing protection from these markets through regulation—licensing, basing medicine on what looks like modern science, raising educational standards, and improving medical schools (Kett 1968).

Second, hospitals did not take all comers. They chose patients based on their social status, often accepting only those recommended by the hospital's patrons (Dowling 1982). They selected patients based on the potential profitability of treating their ailments. Yet courts did not refrain from classifying a charitable hospital "as an eleemosynary institution, even though it may limit its services and benefits to certain classes of society or to patients suffering from certain types of ailments" (Commission on Hospital Care 1947:587).

Both government and nonprofit hospitals always charged fees, although the former were typically lower. (For fee tables from the nineteenth and early twentieth centuries, see Dowling 1982:77, table 17.5). From their earliest days in America, nonprofit hospitals have accepted "patients able to pay a part or all of the cost of their care" (Commission on Hospital Care 1947:537). Of course, those fees were considerably more affordable than they are today.

Throughout the twentieth century, expensive hospital charges have raised policy concerns. A report issued in 1932 by the Committee on the Costs of Medical Care, a self-organized committee of prominent physicians supported by one million dollars of foundation funding that issued fifteen separate reports over five years (Gore 2013), noted that hospital care was out of reach for patient of moderate means (Committee on the Costs of Medical Care 1932). The report describes how "a number of voluntary hospitals in this country are now developing special plans for the so-called 'patient of moderate means,'" including fixed-maximum fee schedules, bill adjustments, and various cost controls such as flat-rate maternity services (these ring to modern ears as something like capitation) (Committee on the Costs of Medical Care 1932:83). Sometimes the government helped poor patients take advantage of these programs through subsidizing treatment, but it left most poor patients behind (Gore 2013). The report's call for insurance was condemned in an accompanying minority report as exploiting medical men and representing "a further step in the commercialization of medicine" and later deemed an incitement to revolution by the editor of the *Journal of the American Medical Association* (Committee on the Costs of Medical Care 1932:175.)

A few years later, a 1947 report from the Commission on Hospital Care, an independent committee formed by the American Hospital Association, made clear that nonprofit

hospitals were not meant for the indigent, distinguishing them from those “maintained by government mainly for indigent patients” (Commission on Hospital Care 1947:168). The report stated, “Independence of operation and the need of attracting wide public interest in the establishment and maintenance of voluntary hospitals have influenced their location in areas offering the greatest prospects for their financial solvency.” (Commission on Hospital Care 1947:170).

Nonetheless, charging fees that were high enough to be self-sustaining yet low enough for patients to afford has posed a challenge for nonprofit hospitals from their beginnings. Eventually, prepaid plans started appearing and then indemnity insurance covered health care costs, including at nonprofit hospitals. “By 1940, 10 percent of the U.S. population had insurance. By 1957 . . . 72 percent of the U.S. population had health insurance” (Kinney 2010:409).

As is the case today, profits from relatively high-paying patients subsidized lower-paying or indigent patients in various ways, such as to purchase capital equipment used for all patients or to subsidize care itself. Using profits in this way—reinvesting them in the hospital—is different from the practice of actively cost-shifting, which involves raising private-pay prices to make up for cuts by public payers. Upon investigation, cost-shifting appears to be less common than frequently assumed (Frakt 2011), particularly given evidence that private payers copy pricing strategies of public payers (see, e.g., Clemens and Gottlieb 2017). Even at the founding of the Pennsylvania Hospital, poor patients were admitted up to the level that they could be accommodated by revenues from interest on the hospital’s stock, and then “the managers shall have the liberty of taking in other patients, at such reasonable rates as they can agree for; and the profits arising from boarding and nursing such patients, shall be appropriated to the same uses as the interest-money of publick stock” (Packard 1963:196).

Nonprofit hospitals have always treated poor people, subsidizing some care to a greater or lesser degree, but they never were exclusively or even primarily organized to provide free care to the indigent. Today, as before, some patients must rely on the provision of free treatment. But if one is to argue that contemporary health care charities are undeserving of their charitable status, it should not be on the grounds that they have strayed too far from their roots in the exclusive provision of free care, as there was no such foundation.

Scholarship on Nonprofit Health Care Organizations

Several literature reviews and metastudies survey research on ownership of nonprofit health care organizations, particularly hospitals (e.g., Herrera et al. 2014; Eggleston et al. 2008; Shen et al. 2007; Schlesinger and Gray 2006a; Rosenau and Linder 2003; Sloan 2000; Gaynor, Ho, and Town 2015). There are also a number of thorough reviews of research on nursing home ownership (e.g., Hillmer et al. 2005; Comondore et al. 2009). Other reviews address ownership and outcomes. For example, Mark Schlesinger and Bradford H. Gray (2006b) categorize studies of hospitals, nursing homes, and managed care organizations by nonprofit or for-profit advantage, finding that nonprofits most often perform better than, although sometimes equal to, for-profits according to several measures of quality, cost, and access. Lisa R. Shugarman, Nancy Nicosia, and Cynthia R. Schuster (2007) provide a limited review of papers studying differences in health care provider costs, demonstrating mixed results. Given the availability of these resources, this section provides only a broad

overview of prior research, mainly citing studies published after the previous edition of this book was released in 2006, except when citing an older study provides context for discussing new areas of attention.

Scholarship on nonprofit health care organizations has concentrated on two sets of questions. First, there is a large and long-standing body of research, particularly quantitative empirical research, asking whether and how nonprofit, for-profit, and (less commonly) government-owned health care organizations differ. Most recently, scholars have considered how nonprofits respond to market conditions, including ownership mixes in the market. Second, scholars have asked whether nonprofits merit federal and state tax exemptions. Most recently, scholars have investigated the relationship between the Affordable Care Act (ACA) and the activities of nonprofit health providers, as well as addressing questions concerning whether nonprofits provide sufficient community benefits to localities.

Although it is beyond the scope of this chapter to address divisions within charitable health care entities, there are important distinctions among them. Indeed, “the Catholic Church owns or oversees the national’s largest group of not-for-profit health care sponsors, systems, and facilities, comprising nearly 12.4% of hospitals in the United States” (Kutney-Lee et al. 2014:135). Whether a provider has a church affiliation may make a meaningful difference for a provider’s community and its patients. For example, religious hospitals are more likely to report to the American Hospital Association that they provide certain listed community benefits than are other nonprofits (Ferdinand, Epané, and Menachemi 2014). Some religious hospitals, particularly Catholic hospitals, limit access to services such as abortion, in vitro fertilization, tubal ligations, or vasectomies in many circumstances. Even within Catholic hospitals there are differences. Kenneth R. White and Roberto Dandi (2009) recently examined the mission statements of Catholic health systems and, although they found tremendous similarities in the statements, they also found that different systems prioritized values differently and some expressed different values altogether. However, if differences among nonprofits (e.g., between religious and secular nonprofit hospitals) were greater than the differences among nonprofit, for-profit, and government entities, the scholars would not have found the outcomes reported in this section. Moreover, there is some evidence that patients do not perceive much of a difference between religious and secular health care nonprofits: “patients treated in Catholic hospitals appear to rate their hospital experience similar to patients treated in non-Catholic hospitals” (Kutney-Lee et al. 2014:140).

Differences Among Nonprofit, For-Profit, and Government Health Care Organizations

Although they have generated mixed findings, in part because they focus on different outcomes and use different datasets, most of the studies on quality of care and service mix find that nonprofits tend to outperform comparable for-profits on service. However, there are fewer differences in studies that concentrate more directly on financial behavior, such as providing free care.

Hospitals. As research reviews suggest, the bulk of analyses focus on hospital behavior. Most recently, a few studies take novel approaches to quality measurement. For example,

Hanadi Hamadi and colleagues (2018) consider the effects of ownership on health in hospital markets, rather than only among hospital patients; they find that hospital referral regions with the greatest number of nonprofits had better affordability, access to care, and prevention and treatment outcomes than government and for-profit hospitals. In a survey of nonprofit hospital board chairs, Ashish Jha and Arnold Epstein (2010) found that board chairs of high-performing nonprofits chose quality as one of their top two priorities, suggesting that hospital performance can be improved through interventions with their boards.

There is considerable recent evidence that nonprofit hospitals offer different services than for-profits. For example, Jill R. Horwitz (2003, 2005, 2007) shows that among urban hospitals, nonprofits are more likely than for-profits to offer relatively unprofitable services, less likely to offer relatively profitable services, and less responsive to financial incentives when profitability changes. The same results hold for rural hospitals (Horwitz and Nichols 2011). Analyzing a 20 percent sample of U.S. community hospitals, Marco A. Castaneda and Dino Falaschetti (2008) find that although nonprofit, government, and for-profit hospitals differ in the quantity of different types of services provided, those differences should not be attributed to ownership itself but rather to the fact that different types of hospitals decide to locate in different types of markets; they conclude that observed differences in care provision likely reflect differences in objectives of the hospitals rather than noncontractible quality and asymmetric information hypotheses. Tom Chang and Mirielle Jacobson (2012) show that financial pressure increases the probability that a nonprofit hospital provides profitable services—a finding inconsistent with both the view that nonprofits are merely “profits in disguise” and the view that they are “purely altruistic,” instead supporting the idea that they maximize output of health services or perquisites for medical staff. In another study, David Dranove, Craig Garthwaite, and Christopher Ody (2017) demonstrate that, on average, nonprofit hospitals responded to reductions in assets related to the 2008 stock market collapse by reducing their offerings of relatively unprofitable services, but not by raising prices, cutting operating costs, or decreasing free care for indigent patients. Theresa Morris, Kelly McNamara, and Christine H. Morton (2017) find that women who give birth in for-profit hospitals are much more likely to have cesareans than women with similar patient-level characteristics in nonprofit hospitals.

In terms of relations with patients, nonprofits “appear more trustworthy in delivering services, being less likely to make misleading claims, to have complaints lodged against them by patients, and to treat vulnerable patients differently from other clientele” (Schlesinger and Gray 2006a:W291). However, Michael Vlassopoulos (2009) has argued that if an organization can establish and sustain an accurate reputation regarding its quality of care, for-profit rather than nonprofit is the preferred form because the for-profit will more efficiently seek to provide high-quality care.

Several studies focus more specifically on financial behavior. Researchers have shown that nonprofits provide considerably more uncompensated care than for-profits, but when adjusted for hospital characteristics, the differences are small (Bazzoli et al. 2006; Congressional Budget Office 2006). That the adjusted difference is not more pronounced has been a topic of great concern to policy makers. However, for-profits are more likely to exit markets, likely in response to financial pressure, than are nonprofits (Miller and Wilson 2018).

Another topic of interest is upcoding, in which hospitals assign an inaccurate billing code to increase reimbursements. All hospitals upcode. However, for-profits are generally more likely than nonprofits and government hospitals to do so (Silverman and Skinner 2004), especially when opportunities to deploy this strategy increase (Dafny 2005), such as when for-profit systems take over the management of hospitals that offer the greatest opportunity to upcode (Dafny and Dranove 2009). Moreover, Paul Gertler and Jennifer Kuan (2009) find that nonprofits and for-profits pay a similar price when buying a for-profit hospital, but nonprofits pay less when buying a similar nonprofit (e.g., a religious nonprofit buying a religious hospital would pay less than a for-profit for the same hospital), suggesting that nonprofits are driven by different objectives, such as aligning the missions of the acquiring and target hospital, than are for-profits.

Yet the behavior of nonprofits is not utterly at odds with that of for-profits. Nonprofits pursue profits, and they engage in accrual-based and real earnings manipulations to reach predetermined targets, particularly to avoid reporting high incomes (Brickley and Van Horn 2002; Leone and Van Horn 2005; Eldenburg et al. 2011; Vansant 2016). Nonetheless, on the whole, the evidence regarding service offerings and financial behavior of nonprofits undermines claims that “all types of enterprise in health care, regardless of type of corporate control, engage in practices to maximize revenues and profits.” (Kinney 2010:424).

The bulk of research on ownership in health care markets focuses on the direct effects of ownership on an organization. However, the indirect effects, through the mix of owners within a market, may be extremely important as well. For example, Jill R. Horwitz and Austin Nichols (2009) find that nonprofits with more for-profits in their markets behave like for-profits by offering more profitable services and fewer unprofitable services and changing their service mix in response to changes in financial incentives. Nonprofit hospitals in markets with relatively high for-profit penetration are also more likely to upcode (Silverman and Skinner 2004). Finally, although hospitals in areas with relatively high HMO penetration have lower cost growth than hospitals in areas with lower HMO penetration, hospitals in areas with high for-profit HMO penetration have even lower cost growth than those in markets with low for-profit HMO penetration (Shen and Melnick 2004).

Another study considered the factors associated with the competitiveness of nonprofit hospital markets, finding that higher donations and levels of Medicare population are positively correlated and median income is negatively correlated with market concentration (Paul, Quosigk, and MacDonald 2017). Finally, Rune Stenbacka and Mikel Tombak (2018) argue that because a for-profit monopoly selects a lower quality than a nonprofit supplier, the socially optimal reimbursement rate with a nonprofit monopoly exceeds that with a for-profit monopoly.

Nursing homes. Several reviews and meta-analyses on ownership in the nursing home industry find significant evidence of higher quality in nonprofit nursing homes compared to their for-profit counterparts (Ronald et al. 2016; Comondore et al. 2009; Hillmer et al. 2005). Measures of higher quality included lower overall probability of a nursing home resident being hospitalized (Hirth et al. 2014), lower probability of being hospitalized for suspected pneumonia (Konetzka, Specter, and Shaffer 2004), fewer thirty-day hospital-

izations and greater improvement in mobility, pain, and functioning after post-acute care (Grabowski et al. 2013), and more autonomy of nurses (Ben-Ner and Ren 2015). Anna A. Amirkhanyan, Hyun Joon Kim, and Kristina T. Lambricht (2008) find that public and nonprofit nursing homes have equal quality, but that public nursing homes have a higher share of Medicaid recipients and, therefore, may provide greater public service. Moreover, among nursing homes in Maryland, facilities owned by for-profit chains (small, medium, and large) have lower quality of care as reported by families than independent nonprofits, facilities in nonprofit chains (which were all small in Maryland), and independent for-profits (You et al. 2016).

Analyses of nursing homes that convert ownership status have also shed light on differences among forms. For example, David C. Grabowski and David G. Stevenson (2008) show that nursing homes converting from nonprofit to for-profit status generally exhibit deterioration in their performance, while nursing homes converting from for-profit to nonprofit status generally exhibit improvement. Anna Amirkhanyan (2008) shows that among nursing homes that converted from government (county) ownership to private ownership, those that converted to nonprofit form did not reduce quality and those that converted to for-profit home reduced quality.

Scholars have also considered the effects of market mix in the nursing home industry, finding that nonprofit market share improves quality among for-profit nursing homes (Grabowski and Hirth 2003).

A recent strand of studies that asks whether nonprofit managers use their organization's status to signal quality rather than to provide high quality is less favorable to nonprofits. For example, Daniel B. Jones, Carol Propper, and Sarah Smith presented evidence that the more that patients have access to information about quality of care, the less likely a provider will choose to be nonprofit status, concluding that nonprofit nursing homes used their nonprofit status for marketing purposes (i.e., as an inaccurate signal of quality to prospective patients) but not to provide quality (Jones, Propper, and Smith 2017).

Other providers: insurers, dialysis companies, home health, and hospice. There is comparatively little research on ownership in the health insurance industry. Much of the existing scholarship has used conversions from nonprofit to for-profit ownership to identify differences among the forms. For example, Ethan M. J. Lieber (2018) finds evidence that when nonprofit insurers convert to for-profit status, the coverage rates of the population in their markets increase, suggesting expanded access to insurance; however, Lieber also found evidence of increased risk selection, suggesting that people who were bad insurance risks may have been worse off after a conversion from nonprofit to for-profit. Leemore S. Dafny (2019) finds that in areas in which the converting insurer commanded substantial market share, the insurer and its competitors all raised premiums and Medicaid enrollment rates increased, suggesting that former beneficiaries of these private insurance plans could no longer afford them. One other study shows no short-term effects of conversion from nonprofit to for-profit status on HMO prices, profit margins, hospital days or ambulatory visits, or the provision of Medicare and Medicaid insured products (Town, Feldman, and Wholey 2004). Others find mixed results on the affordability of coverage and overall spending in states with conversions (Conover, Hall, and

Ostermann 2005) but argue that policy makers should be cautious in relying on early results (Hall and Conover 2006).

Several recent papers have examined nonprofit ownership in the dialysis industry. There is mixed evidence on mortality, with some studies finding a large effect after controlling for risk of patients but no difference when using a different econometric method (i.e., an instrumental variables approach) (Brooks et al. 2006). Other papers conclude that there are higher mortality rates among for-profits (Szczech et al. 2006). Nonprofit dialysis centers appear to outperform for-profits in many other respects. For example, nonprofit dialysis centers are more likely than for-profits to adopt technology to improve quality rather than amenities (Hirth, Chernew, and Orzol 2000), have considerably lower hospital admissions rates (Dalrymple et al. 2014; Lee, Chertow, and Zenios 2010) and complication rates (Straube 2014) than for-profits, are less likely to use EPO (a profitable drug used to treat anemia resulting from kidney disease) than for-profits (Thamer et al. 2007), and are more likely to list patients for transplants and to provide education about transplants with a nephrologist (Balhara et al. 2012) than for-profits. Another recent paper demonstrates that for-profits have financial advantages (Wilson 2016).

Very recently, both the popular press and scholars have focused on ownership in the hospice business. David G. Stevenson and his colleagues (2016) found that for-profit hospice providers were more likely than comparable nonprofits to treat patients for longer periods of time and discharge them alive, suggesting both market segmentation in terms of the patients treated and greater responsiveness on the part of for-profits to profit-making incentives. The authors also found that factors such as organizational size and being a member of a chain of facilities independently contributed to differences. Other scholars have found that for-profits admit more profitable patients than religious nonprofits (Lindrooth and Weisbrod 2007), such as long-term patients and those with particular diagnoses (Wachterman et al. 2011; Aldridge et al. 2014); provide fewer community benefits such as serving as training sites, conducting research, and providing free care (Aldridge et al. 2014); and employ a less professionalized staff (Cherlin et al. 2010). Patients in for-profit hospice also receive a narrower range of services (Carlson, Gallo, and Bradley 2004), as do their families in terms of bereavement services (Barry et al. 2012).

Finally, lower quality of care has also been found among for-profit home health care organizations in terms of the risk of hospitalizations (Decker 2011:202) and the likelihood of discharge within thirty days (Grabowski et al. 2009:140).

Tax Exemption and Community Benefit

The creation of a nonprofit healthcare organization is generally a matter of state statutory and common law, although some organizations are federally chartered charities. Whether a nonprofit enjoys the various benefits often associated with state-designated nonprofit status, including state and federal tax exemptions, is a distinct question of federal and state law. Scholars have done a great deal of writing examining the requirements for nonprofit hospitals and insurers to obtain income tax exemption, arguing over whether those exemptions are justified, and proposing alternative requirements for exemption.

Many of the articles, particularly recently, concern whether nonprofit hospitals provide sufficient benefits to their communities. As Sara Rosenbaum (2016) explains, this focus

stems from growing attention to the social determinants of health, the convergence of business and health interests following Medicare payment reforms penalizing readmissions to the hospital, and new tax exemption requirements, some of which are implied by changes to the form that hospitals must file annually with the IRS and others of which are stipulated under the ACA.

Several scholars have cataloged state laws that require nonprofit hospitals to report the benefits these hospitals provide to their communities (e.g., Hellinger 2009; Gray and Schlesinger 2009a, 2009b; Young et al. 2013). They have also attempted to quantify the value of hospital tax exemptions as well as the amount of different types of community benefit provided. In a 2008 report, the Government Accountability Office estimated the federal income tax exemption of nonprofit hospitals at \$13 billion annually starting from 2002 (U.S. Government Accountability Office 2008). Rosenbaum and her colleagues (2015) placed the value for 2011 at almost double that amount when accounting for state income, state and local sales taxes, and local property tax exemptions.

Others have examined the types and value of community benefits provided by exempt hospitals. Gary J. Young and his colleagues (2013) estimate that in 2009, nonprofit hospitals spent an average of 7.5 percent of their operating expenses on community benefits. Importantly, this percentage varied a great deal among hospitals, ranging from about 1 percent to 20 percent of operating expenses. The vast majority of community benefit expenses went to free care for indigent patients and other patient care services; only a small amount went to direct community health improvement. Susanna C. Tahk (2015) has similarly demonstrated that the bulk of community benefit goes to providing relief for the poor. Other scholars have shown community benefit requirements to be positively associated with spending on free care (Singh et al. 2018, Lamboy-Ruiz, Cannon, and Watanabe 2017).

A large number of scholars suggest that these benefits provided by nonprofit hospitals are inadequate or do not justify the tax exemptions (e.g., Rosenbaum et al. 2015; Rubin, Singh, and Jacobson et al. 2015; Colombo 2007a; Schneider 2007; McGregor 2007). David A. Hyman and William M. Sage (2006) have argued that the wrong hospitals get the largest reward from tax exemption and propose that those rewards should be provided on a graduated basis linked to quantifiable measures of community benefit, broadly and locally defined. It follows from their argument that some community benefits may be more valuable than others. For example, contributing to the public good by improving community health may be more valued by the community than redistributing resources in the form of expensive, high-end medical care.

Many scholars have proposed that more specific or stricter standards than those imposed under the current system should be adopted as requirements for exemptions (e.g., Rubin, Singh, and Young 2015; Rubin et al. 2013; Schirra 2011; Folkerts 2009; Alexander et al. 2008; Kane 2006; Bloche 2006; Colombo 2005). Most recently, some argue that exemptions would no longer be needed given the increase in the percentage of Americans insured in the wake of the ACA (Corbett 2015:153–156).

However, whether community benefits provided are adequate to justify exemption depends a great deal on how they are defined, particularly regarding the treatment of money owed to the hospital that cannot be recovered, known as bad debt (Bazzoli, Clement, and Hsieh 2010). There is a strong argument to be made that critics have focused too narrowly

on the provision of free care for indigent patients. Hospitals make many choices related to community in addition to how much free care to provide (Gray and Schlesinger 2009a). Proposals to condition exemption on free care for indigent patients (as well as any other particular type of benefit) risk unintended consequences, such as a hospital changing its service mix to make up lost revenues. These risks have not been acknowledged in present public debates (Molk 2012; Tyrrell 2010; Singer 2008; Horwitz 2006, 2007).

Even if the ACA had succeeded in insuring almost all Americans—which it did not—exemptions would likely remain valuable. On the one hand, there is strong evidence that insured patients use more, not less care; when people lose coverage, admissions to nonprofit hospitals go down (less than at for-profit hospitals), suggesting that patients with insurance are more attractive to nonprofit hospitals than other patients (Anderson, Dobkin, and Gross 2012) and insurance may reduce the need for subsidies tied to free care. However,

not all insurance will be equally attractive to providers, and nonprofit and government providers are more likely than for-profits to offer services needed by the poor. Moreover, as has always been the case, all patients, regardless of their wealth, are poorly situated to evaluate the care they receive. They need not only to access care, but to trust their providers not to provide too little, too much, or the wrong kind of care. (Horwitz 2016:555).

For example, compared to similar for-profits, nonprofit hospitals were less likely to offer invasive cardiac procedures, including various types of stenting (Horwitz 2005), some of which recently have been shown to have little or no benefit over placebo treatment for many patients (Lancet Editorial 2017). In medical circles the chance findings that come from unnecessary testing are often called *incidentalomas*, and their consequences can be grave when patients are given more unnecessary testing and sometimes dangerous treatment when the patient would have remained healthy without any testing or treatment at all. Although forgoing unnecessary testing and treatment may be worth a great deal in terms of patient health and financial savings for the state, identifying and valuing overtreatment that did not occur is like hearing the dog that didn't bark. It's hard to hear.

Researchers have also turned their attention to state property tax exemptions for charities. They discuss trends in local governments challenging exemption, with some extremely strict applications of tests that involve, for example, requirements for the exclusive use of property for charitable purpose being violated by common arrangements such as the use of contract physicians or an organization of physicians in a manner that leads to collaborative care (Smith and Woodhull 2017; Swogier 2017; Brody 2016; Stewart 2009). State and local taxing authorities have increasingly used various types of payments in lieu of taxes (PILOTs) to raise revenues from nonprofits, particularly targeting hospitals because of their financial resources and their tendency to provide services to people who do not live within the jurisdiction of the local tax area (Fei et al. 2016).

In sum, there is an enormous body of research regarding the significance of nonprofits in the health care sector. Even so, there is room for more. In particular, evidence on nonfinancial outcomes and also on the effects of ownership on markets and the providers in them have been understudied.

The bulk of the research has focused on hospitals and, more recently, on nursing homes. Recently, scholars have expanded their efforts to include insurers, dialysis centers, hos-

pice providers, and other entities. Given the wide variation in specific subjects studied, generalizing across studies can be difficult. Nonetheless, nonprofit providers more likely perform better on a range of important outcomes than do their for-profit counterparts.

Nonprofit and Health Law: The Special Treatment of Health Care Charities

Both of the legal topics centrally implicated in this chapter—health law and nonprofit law—have been subject to the critique that they aren’t distinctive areas of law at all, but are unrelated collections of different areas of law that happen to apply to certain kinds of relationships or entities. In the case of health law, scholars have debated at length about whether the subject has a core set of concerns that form a coherent field or is instead an example of the law of the horse, a collection of general laws that are applied in a specific area (Bloche 2009, Hall, Schneider, and Shepherd 2006). Nonprofit law similarly brings together disparate areas such as trust, corporation, tax, and property law; only now is the American Law Institute drafting its first “Restatement of the Law, Charitable Nonprofit Organizations” to clarify a single law of charities. It is, therefore, unsurprising to find that inconsistencies and even incoherence run throughout the law as it is applied to nonprofit health care organizations.

This section, drawing extensively from Horwitz (2016), considers a few of the major legal and policy areas in which nonprofit healthcare organizations are treated differently from analogous for-profits, and in which nonprofit health providers are treated differently from other types of nonprofits. On the one hand, it addresses tax law as an example of how nonprofit law treats health care organizations *more* restrictively than other types of nonprofits. On the other hand, it addresses antitrust law as an example of how other areas of law treat nonprofit health care providers *less* restrictively than other types of health care providers. These two examples, as well as others, illustrate how sometimes the law treats nonprofits as more suspect and at other times as more trustworthy than comparable organizations. There is no consistent justification for the differences in treatment across legal issues. Indeed, the explanations for the special treatment of nonprofit health care organizations are often contradictory—with more restrictive application of nonprofit law being applied to health care organizations because of their relative commerciality in terms of insufficient efforts to relieve poverty and forgo charging fees, and less restrictive application of other laws being justified because of their relative lack of profit-seeking behavior.

Stricter Requirements Under Nonprofit Law: Tax Exemption

For some time, federal and state laws regarding tax exemption have placed stricter requirements in terms of community benefits on nonprofit health care providers, particularly hospitals, than on other types of nonprofits. In the mid-twentieth century, a series of revenue rulings imposed particular requirements on nonprofit hospitals and insurers seeking federal income tax exemptions and related benefits available to other nonprofits—including income tax exemption, the receipt of tax-deductible donations, the ability to issue tax-exempt debt, and other benefits—that they did not impose on other charities such as museums or schools. From 1956 to 1969, nonprofit hospitals were required to be “operated to the extent of [their] financial ability for those not able to pay for the services rendered” (Rev Rul. 56-185 1956-1 C.B. 202). Since 1969, the IRS has had no explicit charity care requirement for tax-exempt status. Instead, a nonprofit hospital

could secure exemption by either (1) providing free or subsidized care to the extent of its financial ability or (2) meeting an alternative community benefit test, involving treating all patients who were able to pay or were insured, and operating an emergency room where needed (Rev. Rul. 69-545 1969-2 C.B. 117). Federal regulators have interpreted the term *community benefit* broadly.

In response to concern that nonprofit hospitals were not sufficiently charitable in their activities—such as in their aggressive billing policies, particularly billing uninsured patients list rates and insured patients much lower rates (Brooks 2008; Colombo 2007a)—Congress conducted a series of hearings and commissioned studies (IRS 2014; Senate Finance Committee 2006; House Committee on Ways and Means 2005). The IRS created a new schedule (Schedule H) for hospitals to file as part of their IRS Form 990, the federal information return. Although the schedule does not explicitly require the relief of poverty, the relief of poverty figures so prominently in the document that hospitals understand they must provide free care to obtain exemption. It is not surprising, therefore, that a recent analysis finds that hospitals largely spend their community benefit dollars on activities related to poverty relief (Tahk 2014).

In addition, in the early 2000s, plaintiffs' lawyers brought a series of claims against hospitals for inflated billing based on supposed violations of the hospitals' tax exemptions. They lost virtually all of these cases, sometimes based on not having standing and other times more substantively. As Mark Hall (2013) explains, it wasn't that the complaints about unconscionable billing didn't have merit. They did. But the lawyers focused on the wrong legal theory—"they concocted a legal theory based on the federal requirements for maintaining charitable tax exemption"—when what was really at issue was "conventional consumer protection and contract-based claims" under state law (Hall 2013:8). By trying to extend the requirements for tax exemption to even higher standards, the lawyers and the courts missed the opportunity to enforce general laws that apply to all hospitals (Hall and Schneider 2008).

Most recently, the ACA included provisions adding conditions to existing rules for federal tax exemption and related benefits that apply to charitable hospitals otherwise eligible for exemption under § 501(c)(3) (I.R.C. § 501[r] [2015]; Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78954-01 [December 31 2014]; Crossley 2016). Hospitals that are charities must (1) establish financial assistance and emergency medical care policies, (2) limit charges to patients eligible for assistance under those policies, and (3) make reasonable efforts to identify eligible patients before engaging in extraordinary collection actions against them. Hospitals must also conduct community health needs assessments and adopt implementation strategies to meet those needs at least once every three years. Hospitals that do not report on and comply with the requirements face a \$50,000 tax and risk losing their tax exemptions altogether.

The tax treatment of health insurance companies similarly has varied over time. Many nonprofit insurers were fully exempt until 1986, when the Tax Reform Act made insurers that provide "commercial-type" insurance as a substantial part of their activities ineligible for exemption (Hill and Mancino 2002; Supp. 2014-2 at 22.06). Certain insurers were still able to qualify for preferential tax treatment in the form of special deductions as long as they met certain requirements, such as maintaining high-risk and small-group coverage plans (I.R.C. § 833 [2015]).

There also has been considerable activity at the state level, largely regarding the exemption from local property taxes. States typically grant income tax exemption to entities that are eligible for federal income tax exemption, although some state statutes and constitutions contain provisions that include different, usually more stringent, requirements for exemption. Because many nonprofit health care entities do not earn significant profits but do own real property, property tax exemptions can be more valuable to these organizations than income tax exemptions. Because local governments have been under financial strain in recent years, they have turned to nonprofits—especially hospitals but also large universities—to help produce revenue to cover these shortfalls.

These local government strategies include increasing restrictions on property tax exemptions. Some states have imposed or increased community benefit requirements linked to these exemptions (Klebes 2015; Stewart 2009; Goodman 2009; Hellinger 2009). For example, Pennsylvania hospitals can meet the requirement by providing uncompensated care in an amount equivalent to at least 5 percent of net patient revenue (10 Pa. Stat. § 375[d][1][iii] [1997]); applicants for a hospital license (or any subsequent successor or acquirer) in Massachusetts must agree to maintain or increase the percentage of patient revenue allocated to uncompensated care (Mass. Gen. Laws 111 §51G[3] [2000]) Many localities have negotiated for donated services (Brody 2007) and PILOTs (Fei et al. 2016). At the extreme, some local governments have denied hospitals' claims for property tax exemptions altogether (e.g., *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 236 Ill.2d 368 [2010]; *AHS Hospital Corp. v. Town of Morristown* 28 N.J.Tax 456 [2015]).

The underlying message is that nonprofit hospitals are not sufficiently charitable because they don't do enough to relieve poverty. Of course, the relief of poverty is important and these heightened requirements for nonprofit health entities may increase the provision of free care for indigent patients, but doing so may well come at the expense of other patients and other charitable obligations such as providing high-quality care, providing unprofitable services, or forgoing the provision of some profitable services (Horwitz and Cutler 2015). Although there is political pressure on other types of charities to address problems associated with poverty, such as encouraging universities to grant admission and provide benefits to first-generation students, no other type of charity is required to relieve poverty to qualify for property tax exemption.

Lenient Requirements Under Health Law

There are many examples of health and related laws treating nonprofit health care providers more leniently than analogous for-profits, and various justifications have been advanced for this leniency. Most are based on some version of the idea that nonprofits are more trustworthy than for-profits because they are not (or are not as) motivated by seeking profits as are otherwise comparable for-profits or, less plausibly, because they are thought not to compete at all. Having their focus on something other than seeking profits, so the justification goes, will lead nonprofits to more readily act in the interest of their patients and, therefore, nonprofit health care organizations don't need to be so tightly regulated. These justifications are often at odds with the calls for restricting or removing tax exemption discussed earlier.

This section addresses the favorable treatment of nonprofits under the corporate practice of medicine doctrine. However, this is not the only example of readily favorable

treatment of nonprofits by health or related law. Horwitz (2016) discusses other examples in detail: the ACA's extensive reliance on nonprofits, the (changing) history of courts applying antitrust law so as to allow nonprofit hospitals to merge because of an assumption that nonprofits do not compete on prices or would not raise prices after a merger, charitable immunity in tort law, and the different treatment of hospital and insurer conversions depending on whether they are converting to or from nonprofit form.

The corporate practice of medicine doctrine typically forbids corporations from directly employing physicians to provide medical services. These restrictions can be found in state statutes, common law, and medical licensing rules that imply that only human professionals and not legal persons, such as corporations, can practice medicine (Axelrod 1997). Although the law is strictly observed only in some states, it remains on the books in many others and influenced the development of what are now customs in corporate structure (Sage 2016; Hall 1988). For example, it explains why hospitals tend to have contractual arrangements with their medical staff rather than employing them directly, and why insurers do not technically pay doctors for care; rather, beneficiaries assign payments to their doctors by contract.

The rules are mainly meant to protect patients by insulating the independent judgment of physicians from commercial pressure and, according to some scholars, such rules are also meant to protect the status and income of physicians (e.g., Fichter 2006). The law presumes that contractual relationships do not raise these same risks.

States tend to exempt certain entities, frequently nonprofits, from corporate practice rules (Mars 1997; Axelrod 1997; *Berlin v. Sarah Bush* 1997 at 11–12; *Grp. Health Ass'n v. Moor* 1938 at 446–447). The exemption for nonprofits generally rests on the idea that because they aren't motivated by profits, nonprofits can avoid “the principal evils attendant upon corporate practice of medicine [that] spring from the conflict between professional standards and obligations of doctors and the profit motive of the corporate employer” (Michigan Attorney General 1993, quoting *People ex. rel. State Bd. of Medical Examiners v. Pac. Health Corp. Inc.* 1938 at 431; Hansmann 1981:580–585). The California Court of Appeals similarly concluded that “concerns about for-profit corporations have nothing to do with non-profit teaching hospitals” (*California Med. Ass'n, Inc. v. Regents of Univ. of California* 2000 at 550).

As with developments regarding the charitable income tax exemptions, states have begun limiting the exemption from corporate doctrine practice for nonprofits. California now exempts only charities that do not charge patients and various community clinics (Cal. Bus. & Prof. Code § 2400). The justification for applying the doctrine to nonprofits is that the dangers of lay control over physician practice are not limited to profit-seeking and, therefore, even if nonprofit lay owners would not steer physicians toward profit-seeking to the same degree as for-profits, they might nonetheless jeopardize independent caregiving by encouraging some profit making or try to direct care for other institutional and non-medical purposes (*California Physicians' Serv. v. Aoki Diabetes Research Inst.* 2008 at 1515–1516). In Illinois, which has been the leader in challenging nonprofit hospital property tax exemptions, the state supreme court maintained that nonprofits, like for-profits, can disrupt the “safeguarding [of] the physician's professional judgment from lay interference or protecting the public's general health and welfare” (*Carter-Shields v. Alton Health Inst.* 2002 at 460).

As with the application of other laws, such as antitrust, the history of exemption for nonprofits from the corporate practice doctrine highlights the presumption that nonprofit status insulates organizations from a degree of profit-seeking that would interfere with the practice of medicine and, therefore, protects patient welfare. On the other hand, perhaps they shouldn't be trusted given the finding that nonprofit health care employees have been found to demonstrate what researchers have identified as Machiavellian tendencies, such as acting in an impersonal, rational, and strategy-oriented manner rather than person-oriented (Richmond and Smith 2005).

In sum, the way the law treats nonprofit health care entities seems to depend not on the behavior or characteristics of those entities themselves but rather on those of the organizations to which they are being compared.

Conclusion

The charitable sector encompasses a striking diversity of organizations. That these organizations vary tremendously in size, age, scope, financing, and purposes makes it impossible to define the sector precisely. Nonetheless, a conventional image of "charity" persists and is challenged by the presence of health care nonprofits of the sort discussed in this chapter. Rosemary Stevens's observation that hospitals "carry the burden of unresolved, perhaps unresolvable contradictions," continues to be true (Stevens 1989:361).

Considered in the context of health care and of their history, however, their rightful claim to charity status becomes clear. There was no golden age when health providers acted entirely outside commercial markets, serving those in need without compensation. Neither government nor donors have ever been willing to provide resources sufficient for health care charities to deliver all the care patients need. Therefore, health care charities have always had to be self-sustaining, which has meant charging for services and finding various other avenues for generating revenues. The need to find revenues has grown as health care has become more effective and more expensive. We should not bemoan the necessary commercialization. At least some commercial activities have allowed health care charities to cross-subsidize in terms of both underwriting care for poor patients and, as importantly, refraining from oversupply of profitable services.

Nonprofit health providers, in fact, do well when compared to existing for-profits rather than to folklore about nonprofit medical providers in olden times. Although this advantage may not be expressed in every dimension, by important measures nonprofit health care providers outperform their for-profit competitors. The evidence suggests they have different goals than for-profits, particularly being less profit-seeking than otherwise comparable for-profits. Whether these differences are sufficient to justify tax benefits is a separate and, particularly at the local level, a somewhat difficult question. But asserting that they are not charitable because they are unlike other types of charities in terms of relying on donations or relieving poverty is at a minimum ahistorical and in a larger sense discounts their enormously important role in the sector.

Indeed, a more sympathetic eye might find that nonprofit health care providers are players in good standing in the sector and offer the potential to solve some of the pressing health policy challenges we face. In fact, Schlesinger and Gray (2006a), the co-authors of an earlier version of this chapter, advocated for a recommitment to nonprofit providers as

one way of fulfilling the increased need for trust in the health care sector as policy makers take an evidence-based turn that risks neglecting harder-to-measure values. Protecting community benefits that aren't readily captured in economic figures is precisely the kind of role that a good charity ought to play.

Finally, in describing the role of nonprofits in health care markets, their commercial history, and how they differ from other health care providers, this chapter should not be mistaken for a full-throated embrace of commercialism. Many thoughtful scholars have highlighted the social significance of health care institutions operating in commercial contexts, particularly the hospitals in which many of us are born and die. Such studies have found these institutions coming up short. For example, Rosemary Stevens's *In Sickness and in Wealth: American Hospitals in the Twentieth Century* remains an apt analysis of the ways in which hospitals reflect and contribute to power dynamics in American society and should still serve as a call for improvement. On a larger scale, we have been unable to harness the political will to provide universal insurance or to take adequate steps for cost control.

Nonetheless, nonprofits play a unique, often positive, role in contemporary health care provision. Setting up historical straw men against which to judge them or overestimating their similarities to other providers risks misunderstanding their contribution and potential.